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# Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss

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# FORECLOSING MEDICAL MALPRACTICE CLAIMS BY PROMPT TENDER OF ECONOMIC LOSS\*

*Henson Moore\*\* and Jeffrey O'Connell\*\*\**

As a former student and a current colleague of Wex Malone in the law of torts, we join in paying tribute to him as one of the great teachers and scholars in the history of American law.

We believe that a fitting tribute is to take this occasion to discuss our proposal for reform of the medical malpractice system—a proposal that builds on Wex's teaching and on his insights into the ever-changing law of torts.

One of us had the privilege to be a student of Wex. As such he came to appreciate a man he now calls "the great educator, ruminator, and interrogator." He believes no one could have been subjected to Wex's Socratic method of teaching and not have been forever changed. He considers Wex one of his most memorable mentors. He entered into private practice and on occasion tried medical malpractice cases under the current tort law system. He now participates in enacting the laws of the United States as a member of Congress.

The other of us is a colleague of Wex's in academe, a student of his learned observations of the tort law, as well as a friend.

Severally we have been touched and guided by Wex. Together we propose a reform in the medical malpractice system.<sup>1</sup> We believe the current malpractice system, based on adversarial contests between healers and patients to determine and allocate fault, fails to serve the best interests of patients, those who care for them, and the public at large. Our proposal is embodied in H.R. 5400, introduced on April 10, 1984.

## THE CURRENT SYSTEM

Medical malpractice is adjudicated as torts conventionally have been over the last 135 years: a victim seeks compensation for loss occasioned by another's negligence; the award may include not only reimbursement for the actual monetary loss suffered, but also payment for a variety of

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1. We have been brought together by the National Council of Community Hospitals, an organization of community hospitals devoted to making reforms in the delivery and financing of health care.

non-economic injuries, including loss of consortium and pain and suffering, sometimes augmented by punitive damages supposedly designed to punish and deter the tortfeasor.<sup>2</sup> The determination of fault requires complex and unpredictable litigation which attempts to unravel the largely unknown mysteries of disease and illness and to determine the appropriateness of treatment procedures about which even the experts are often bitterly divided. The process is lengthy, and the results are erratic. Some victims recover nothing. Others receive less than fair compensation. At the other end of the spectrum, a few plaintiffs recover amounts far in excess of their actual losses. Large portions of the awards depend on subjective and emotional considerations. The results are often fortuitous, and huge transaction costs are required to operate the system.

It is difficult to prove fault in any personal injury case, but the difficulty of proving whether a driver was driving too fast or under the influence of chemicals pales in comparison with the task of determining whether an adverse result in the course of health care resulted from negligence—and whether the negligent party was the physician, hospital, drug manufacturer, equipment manufacturer, or any of the multitude of others who participate in providing care. Jurors may feel comfortable deciding whether a driver was negligent; this determination is within their own personal and ordinary experience. But since not many jurors have had to diagnose disease or perform surgery, the system requires a battle between phalanxes of expensive expert witnesses. The jury must choose between two often diametrically opposed views of what the defendant physician should have done (with the plaintiff's view tailored by hindsight). The process is inevitably complex, time-consuming, and expensive; the result is ineluctably erratic.

The erraticism is further exacerbated by the provision in the current tort system for payment for non-economic damages, such as loss of consortium and pain and suffering, and for punitive damages. These items represent the "big hit;" yet they are entirely subjective and must be determined in the discretion of the jury. There is no formula for translating such non-pecuniary items into pecuniary terms. The plaintiff inevitably appeals to the jury's sympathy with highly emotional evidence. Recovery depends on the appearance of the plaintiff as well as on the circumstances of the plaintiff's life. An attractive young female may receive higher payments than a working man for the same injury, and disability to a child is worth more still. The award also increases when the plaintiff is substantially older, presumably because the elderly, like the very young, are seen as vulnerable and therefore excite sympathy when hurt.<sup>3</sup>

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2. For discussions critical of the efficacy of punitive damages—especially for negligent, as opposed to intentional, injuries, see *Symposium, Punitive Damages*, 56 S. CAL. L. REV. 1 (1982).

3. O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims*

Because of the difficulty of proving causation, those who are injured by negligence in the health care system do not necessarily recover their damages. Because of the fortuity and subjectivity involved in the award of non-economic damages, some plaintiffs are able to recover far more than their actual damages, while others similarly situated recover less—or nothing. The results are no more predictable than a lottery.

Another factor increases the windfall nature of recoveries. Damage awards paid by tortfeasors frequently duplicate amounts paid to the victims from collateral sources. The victim thus collects twice. In some instances the collateral source recovers the amount paid to the victim by virtue of subrogation, but to the extent that subrogation is effective, the use of insurance premiums has been inefficient since the same event has been covered by two different carriers, one insuring the tortfeasor and the other paying the victim<sup>4</sup> (although premiums should be lowered to reflect the possibility of subrogation, it is not apparent that this adjustment actually occurs).

The tort system does not, therefore, fulfill the purpose it presumably was intended to serve. It does not provide a fair and rational method for compensating victims of medical malpractice. And yet society pays high costs for operating this unsatisfactory lottery.

The process requires patients and providers in many cases, particularly where there has arguably been negligence, to assume stances diametrically opposed to what they want. A patient must accuse those who have cared for him and whom he may need to continue to care for him. The providers must deny culpability for an outcome they believe they may be responsible for.

The relationship between hospital and physician is poisoned as each (typically through separate insurance companies) points the finger of fault at the other. Their ability to provide care is disrupted by the need to prepare a defense. Physicians who are sued even though they believed they did their best often become depressed and suffer diminished productivity.<sup>5</sup> Malpractice awards increase insurance premiums, causing

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by *Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U. L. REV. 589, 592 (1982).

4. O'Connell, *A Proposal to Abolish Contributory and Comparative Fault, with Compensatory Savings by Also Abolishing the Collateral Source Rule*, 1979 U. ILL. L.F. 591, 604-05.

5. A report by the Board of Trustees of the American Medical Association finds that "the biggest cost" of suits brought under the malpractice system is "the emotional injury that a physician experiences when he or she believes that he or she has done the best possible under difficult circumstances. Decreases in physician productivity as a result of such dysfunction cannot be estimated." Report, Board of Trustees [American Medical Association], Study of Professional Liability Costs (Substitute Resolution 8, A-82) Report: N(1-83) p. 15 (1983) [hereinafter cited as Report].

physicians to raise their fees. Risk of suit causes physicians to decline to undertake the more difficult procedures, and sometimes to retire. The fear of malpractice forces doctors to practice defensive medicine, providing more tests and procedures than they otherwise would, and thus subjecting patients to unnecessary services and raising the costs of health care to all Americans. A recent report by the Board of Trustees of the American Medical Association estimates that defensive medicine consumes in excess of \$15 billion annually in physician costs.<sup>6</sup>

Attorneys' fees consume large amounts of money that would otherwise be available for victims. Defendants and their insurance companies must pay in every case, while plaintiffs who win must yield a large percentage of their recovery in the form of contingent fees. It is estimated that the medical malpractice tort system returns at most only twenty-eight cents of the premium dollar to injured patients, of which only 12.5 cents reimburses the victim for pecuniary losses not compensated by other sources.<sup>7</sup>

No one benefits from the present malpractice system other than the lawyers and expert witnesses who thrive upon it.

The present system is particularly unresponsive to the needs of Medicare beneficiaries. They file malpractice claims at a rate roughly one-fourth of the rate at which patients under sixty-five years of age do.<sup>8</sup> The fact that earning capacity, and thus the potential recovery for economic loss, declines for most persons over age sixty-five partially explains this discrepancy. There are other factors as well. Medicare beneficiaries are less likely to want to become involved in the judicial system. They are less willing to engage in an adversarial dispute with the physician who is treating them; they perceive a more immediate and continuing need for his care, and they fear they may not be able to find another physician. Their shorter life expectancy does not permit them the luxury of waiting for the outcome of years of litigation.<sup>9</sup> Medicare beneficiaries in particular would be better served by a system that provides them more assurance of fair compensation, quickly recognized, for their real losses rather than the hope (often little more than the will-o'-the-wisp) of a windfall recovery after years of bitter litigation.

#### THE TORT SYSTEM IN CHANGING CONDITIONS

This country has recently begun a fundamental reevaluation of how it determines the use and allocation of economic resources as it comes

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6. *Id.* at 14.

7. O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries*, 60 MINN. L. REV. 501, 509 (1976).

8. P. DANZON, *THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS* 26 (1982).

9. It has recently been estimated that "it takes an average of seven years to adjudicate a malpractice claim." J. Commerce, Jan. 16, 1984, at 9C, cols. 4-5.

to recognize that these resources are not as limitless as decision-makers since World War II had assumed. Health care is an important component of this reevaluation. Policymakers are beginning to realize that new methods must be developed to finance and deliver health care more efficiently and more innovatively. We believe a proposal to provide a less wasteful and more just means for compensating people for injuries caused by the health care system would be an important part of this reform effort. We must not assume that the present system is inevitable or immutable. We can reshape the tort system so that it better serves society.

The shape of the tort system has varied over the years as the needs of the times have changed. For instance, Wex has explained in a learned piece published in an earlier volume of the *Louisiana Law Review*, what might seem, at first blush, an irony: the contraction from absolute liability to fault in the English common law accompanied the economic expansion of England in the nineteenth century.

It is difficult to escape the conclusion that the liberality toward the defendant's predicament in [early] . . . traffic cases [under absolute liability] was an outgrowth of the practical dilemma for litigation that was shaping up as the roads of nineteenth century England were gradually improved. Courts were faced with the fact that there was a pressing interest in the full utilization of the highways, and that decisions mechanically rendered in favor of victims under the Trespass [or absolute liability] theory would have a serious adverse effect on highway users. An impressive group interest in travel had emerged and courts were impelled to take it into account. Hence the plaintiff, if he were to recover, must make a presentation with greater appeal than a mere showing that his injury was "directly" inflicted. It became apparent that under the strict Trespass action, no traveler could afford to risk his fortune by making use of the highways. Thus the idea of negligence emerged as an inviting compromise in these cases: let the driver do all that he can to avoid a mishap, and if an accident nevertheless occurs, he will not be held responsible. In this way each traveler received some—but not complete—protection, and all were afforded an opportunity to avoid liability by so conducting themselves as to reduce the accident risk to a minimum.<sup>10</sup>

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From mid-century onward the trend toward the fault requirement became precipitous. There was emerging a new industrial society made up of men who ventured their capital on the mass fabrication of goods in mechanized establishments and who

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10. Malone, *Ruminations on the Role of Fault in the History of the Common Law of Torts*, 31 LA. L. REV. 1, 33-34 (1970) (footnote omitted).

transported their products throughout the nation on fast moving steam railways. Society was fast migrating to the urban centers. There was wealth to be had and wages to be earned—but all at high risks in terms of safety. The new society in its dangerous world was viewed by the courts as one that was willing to compromise safety for economic advantage; and negligence afforded the means whereby concessions could be made. A live-and-let-live postulate which was first manifest in the early traffic cases had eventually become the attitude adopted by an entire nation. Indeed, the pendulum of change had made its full swing before the century expired and the courts found themselves pressed to withhold liability for harm inflicted by the industry and transportation enterprises even where fault was obvious. Immunities, sharply limited duties, and elaborate defenses were urged upon the courts, and often with considerable success.<sup>11</sup>

So, as Wex tells us, the law started with absolute liability (really a form of no-fault) and turned to fault-based liability as a way of limiting liability. Indeed, Wex went on to indicate that liability based on fault may now be outmoded—and that we must not be rigid in our thinking because of the law's past reliance on fault-based liability.

As the concept of tort liability gradually emerged from its medieval chrysalis and became nascent in English history it afforded little indication that the existence or nonexistence of defendant's blameworthiness was a matter of much concern to the law. This held not only for the early Anglo-Saxon proceeding, but for its eventual successor, the suit in Trespass, and even for the later developed action of Trespass on the Case. The suit in Case, however, did introduce the notions of *duty* and *neglect* which were destined to serve as the bases for the eventual appearance of the negligence requirement in the traffic cases later in the nineteenth century.

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In referring to the history of negligence prior to the nineteenth century Professor Winfield observed that "It is a skein of threads, most of which are fairly distinct, and no matter where we cut the skein we shall get little more than a bundle of frayed ends." Indeed, this same observation can be made concerning the fault picture throughout the nineteenth century and even up to the present day in England. We are likely to gain a deeper insight into the significance of fault (or the lack of it) by fixing our attention upon the particular type of human activity involved and upon

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11. *Id.* at 40-41.

the economic and social demands of the time and place than we can gain by paying reverence to the language of the judges as they have undertaken to serve as spokesmen for their own society.<sup>12</sup>

We believe that at this "time and place" the tort system is not adequately serving those who are involved in the "human activity" of health care, and that the application of fault should be modified. Our thesis is that in medical malpractice some modifications of fault-based liability are now necessary to provide a fairer and more efficient means of compensating more victims for injury.

Periodically the tort system has been modified to provide a more efficient and fair system and to correlate more accurately the injury and the need for compensation. One of the first efforts out of the vicious cycle of the tort system was the workers' compensation laws originally enacted in Germany in the late nineteenth century and adopted in this country early in the twentieth century. Workers injured on the job had been required to prove the fault of their employers. Concerned employers in the United States recognized that this burden required huge transaction costs and was an inefficient method of paying needed compensation. They were instrumental in persuading lawmakers to institute a new system providing for payment without fault for injury arising out of employment. This system eliminated arguments over fault in industrial accidents and paid injured workers on the basis of their economic loss.

More recently, no-fault automobile insurance has been developed to mitigate the tort system in another area. Each party to an accident is paid regardless of who is at fault; in exchange, each party is compensated only for his net economic loss, and correspondingly he waives his tort action against the other.<sup>13</sup>

Various surveys have demonstrated that no-fault automobile insurance when properly structured permits a smaller percentage of the premium dollar to be spent on legal fees and other transaction costs, compensates more injured victims, and pays claims more promptly. Dollars formerly used to pay non-pecuniary losses are used to pay more pecuniary losses.<sup>14</sup>

It appears the success in automobile no-fault has had a spillover effect in the medical malpractice and products liability area. These claims

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12. *Id.* at 43-44 (footnote omitted) (quoting Winfield, *The History of Negligence in the Law of Torts*, 42 LAW Q. REV. 184, 185 (1926)).

13. For a discussion of no-fault auto insurance laws and their operation, see O'Connell, *Operation of No-Fault Auto Laws: A Survey of the Surveys*, 56 NEB. L. REV. 23 (1977); O'Connell & Beck, *An Update of the Surveys on the Operation of No-Fault Auto Laws*, 1979 INS. L.J. 129; see also Williams, *Insurance Hassle: No-Fault Auto Policies Are Widely Attacked as Costly, Ineffective*, WALL ST. J., Nov. 16, 1983, at 1, col. 6.

14. See authorities cited *supra* note 13.



now comprise a much greater portion of personal injury claims than before the advent of automobile no-fault. Lawyers finding one market diminished—or at least threatened—may have entered into the other.<sup>15</sup> According to one source, fifty percent of the responding attorneys stated that they saw little or no evidence of malpractice in more than half the cases they took.<sup>16</sup>

A recent survey conducted by Yankelovich, Skelly and White for the All-Industry Research Advisory Council asked respondents to choose from a list of eleven possible reasons for the increase in malpractice lawsuits. Their responses (in percent) were the following:

People are more aware that they can sue	63
People want to make money on lawsuits	55
Doctors do unnecessary operations	53
Lawyers encourage lawsuits to make money	52
Publicity about big awards encourages more lawsuits	48
Lawyers are more willing to sue doctors today	39
Doctors get careless	37
People expect doctors not ever to make mistakes	36
Doctors charge too much	28
Doctors see too many patients	22
Hospitals are understaffed	20 <sup>17</sup>

Medical malpractice claims are increasing, as are judgments and costs. Premiums are increasing and insurance companies are pulling out of the market. We seem to be approaching another malpractice crisis like the one between 1974 and 1975.

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15. J. O'Connell, *The Lawsuit Lottery: Only the Lawyers Win* 172-73 (1979) (adapted from O'Connell, *supra* note 13 at 44-45). A recent study suggests, however, that the introduction of no-fault does not affect the frequency of medical malpractice claims, but may increase the amount of each claim (a result the author believes may be spurious). P. DANZON, *supra* note 8, at 29. As Danzon points out, the full effect of the introduction of no-fault automobile insurance has not been experienced because in most instances the thresholds at which tort actions could be brought were set too low.

16. Van Scoy-Mosher, *An Rx for the Malpractice Explosion*, L.A. Times, June 28, 1983, reviewing D. Flaster, *Malpractice: A Guide to the Legal Rights of Patients and Doctors* (1983).

17. All-[Insurance] Industry Research Advisory Council (AIRAC), *Public Attitude Monitor 1983: A Public Attitude Survey on Drunk Driving, Medical Malpractice, Seatbelts, and Other Insurance and Safety-Related Topics* 24 (Oct. 1983). For a searching analysis of various putative causes of the rise in medical malpractice litigation, see Robinson, *Medical Malpractice: Thoughts Out of Season*, nn. 37-93 (1984) [hereinafter cited as Robinson, *Thoughts*] to be published in two parts in somewhat altered form in 1985 NAT'L J. LAW AND CONTEMP. PROBS.

Ten years ago, a rapid and dramatic expansion in recoveries caused a number of insurers to withdraw from the market. Those which remained raised their rates. One consequence was the organization by physicians and hospitals of their own captive insurance companies. The states responded with a number of "reforms," such as providing for voluntary arbitration, modifying or affecting the collateral source rule which prevented juries from considering plaintiffs' other sources of money, introducing screening panels, tightening statutes of limitation, and limiting the size of contingency fees.<sup>18</sup> A recent study of the effect of these reforms found, on the basis of data through 1978, that the increase in the frequency of claims leveled off after 1976. It questioned, however, whether this was the result of these tort reforms, since the deceleration trend was not confined to medical malpractice and was observed in the tort system more generally.<sup>19</sup> Furthermore, even while the frequency of claims was leveling off, the study found the severity per patient claim increased between 1975 and 1978 by an average annual rate of roughly thirty percent. It found no effect on severity of claims from most of the reforms, but it did find an effect from those laws which placed a cap on recoveries and which mandated the offset of compensation from collateral sources.<sup>20</sup>

The reforms, therefore, at best had an isolated and limited effect through 1978. As suggested above, more recent experience indicates that another malpractice crisis is imminent. Awards and settlements are increasing. Data collected by the Socioeconomic Monitoring System of the American Medical Association in July and August of 1983 revealed that the average incidence of claims per 100 physicians increased from 3.3 to 8.0 in the period from 1978 to 1983.<sup>21</sup> Between 1978 and 1981 the number of jury awards in excess of \$1 million increased from thirteen to forty-five. For awards less than \$1 million, the average award per claim increased from \$174,400 to \$251,500.<sup>22</sup> Malpractice premiums, it is estimated, will increase 20-30% this year, "with no relief in sight in the near future."<sup>23</sup>

Data derived by the AMA's Socioeconomic Monitoring System in 1983 show that physicians have responded to premium increases by various ac-

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18. P. DANZON, *supra* note 8, at 39-48, app. A. For an extensive discussion of the reforms, see Robinson, *Thoughts*, *supra* note 17.

19. P. DANZON, *supra* note 8, at 2, 29.

20. *Id.* at 30. For a further discussion of the effects of the reforms, see Robinson, *Thoughts*, *supra* note 17.

21. Report, *supra* note 5, at 6.

22. Lavin, *Malpractice, A New Storm is Looming*, Med. Econ., Oct. 3, 1983 at 83; see also P. Carlin, *Medical Malpractice Pre-Trial Screening Panels: A Review of the Evidence*, (Intergovernmental Health Policy Project, Geo. Wash. U.) 6-7 (1980); Curran, *Medical Malpractice Claims Since the Crisis of 1975: Some Good News and Some Bad*, 309 NEW ENG. J. OF MED. 1107 (1983).

23. Bus. Ins., Sept. 26, 1983, at 1.

tions, the most frequent of which were: maintaining more detailed patient records (56.7%); referring more cases to other physicians (44.8%); prescribing additional diagnostic tests (40.8%);<sup>24</sup> spending more time with patients (35.9%); not accepting certain types of cases (34.6%); and increasing fees (31.4%).<sup>25</sup>

A recent survey of obstetricians/gynecologists reveals similar results. More than 76% of those surveyed said that they have increased their testing and other diagnostic procedures in response to the threat of malpractice suits.<sup>26</sup> Liability insurance was said to be the most important factor (exceeding even inflation by a small margin) in the decision to make fee increases,<sup>27</sup> and more than 74% (in excess of 90% in Florida and New York) reported that the increase in the cost of malpractice insurance had directly affected their professional fees.<sup>28</sup> Thirty-two percent restricted their practice because of the threat: for example, they decreased the amount of high-risk procedures they perform, or eliminated their obstetrical practice.<sup>29</sup>

Admittedly we cannot be sure of the effects, if any, of such actions on the quality of health care. But they do seem to substantially increase health care costs by causing physicians to practice defensive medicine.<sup>30</sup> By definition, physicians are taking these defensive steps not because they believe there is a medical justification for them but because they perceive inappropriate pressure from the tort system. A revival of the malpractice crisis will further accentuate these trends and further raise health care costs.

At the same time, injured patients are not being adequately served. A study of patient outcomes performed in 1974 under the joint sponsorship of the California Medical Association and the California Hospital Association found potentially compensable events (disabilities caused by health care providers) in 4.65% of hospital admissions, but concluded that only 0.79% of admissions could probably result in payment based on fault.<sup>31</sup> Thus, if this study is correct, patients might be expected to recover, at the most, in only 17% of potential hospital injury cases.

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24. In addition, 27.2% reported providing additional treatment procedures. Report, *supra* note 5, at table 3.

25. *Id.*

26. See Porter, Novelli & Assocs., Professional Liability Insurance and Its Effects: Report of a Survey of ACOG's [American College of Obstetricians and Gynecologists] Membership Table 22 (1983).

27. *Id.* at Table 20.

28. *Id.* at Table 26.

29. *Id.* at Table 22.

30. For an argument that the adverse effects of defensive medicine on the quality of health care, adduced by fear of malpractice liability, have not been proven, see Robinson, *Thoughts, supra* note 17. On the general subject of deterrence, see authorities cited *infra* notes 55-58 and accompanying text.

31. Summary Highlights, Medical Insurance Feasibility Study (Calif. Med. Assoc. and

## NO NO-FAULT MALPRACTICE

Medical malpractice might therefore appear an appropriate area for application of the no-fault concept. However, there are substantial reasons for not doing so. Chief among these is the difficulty of determining when a compensable event occurs or, stated differently, what events should be compensated.

We can say with some degree of certainty that an automobile accident occurs because the drivers were driving on the road and not because of some other pre-existing or extrinsic cause (with exceptions for cases in which a driver has a heart attack, a tree falls on the road, or a typhoon sweeps a car away). One can under most circumstances expect to navigate the streets safely, and if that expectation is not achieved, it is almost invariably the result of an event which occurs on the road. Accordingly, the no-fault automobile insurance system typically compensates a motorist for injuries "arising out of the ownership, maintenance or use of a motor vehicle," and need not further differentiate among accidents that will be covered.<sup>32</sup>

In medical care, however, it is far less clear whether the lack of success from medical treatment is the result of improper medical care or merely from the natural workings of disease. Disease and death are inevitable. Society could in theory introduce a no-fault insurance plan providing for the payment of benefits if treatment is not successful. This plan would be the conceptual analogue of automobile no-fault insurance: payment for an untoward event occurring in the course of a specified activity. But because death is inevitable and because the treatment of disease is only to a moderate extent within the control of man, such a plan essentially would be a national life, health and disability insurance program. It would pay benefits regardless of fault for every death and even for all morbidity occurring in the course of medical treatment. This result would be not unlike New Zealand's national accident insurance scheme, which pays unlimited medical expenses and limited wage losses resulting from accidental injury.<sup>33</sup>

But to introduce such a scheme for all health care would represent a massive shift of resources. It could not be financed privately, but would

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Calif. Hosp. Assoc., Aug. 1977). For other estimates showing similar disparity between potentially compensable adjustments and claims made, see Robinson, *Thoughts supra* note 17.

32. As to problems of legal causation under a no-fault law, see J. O'Connell & R. Henderson, *Tort Law, No-Fault and Beyond* 362-65 (1975). That a tortfeasor other than a motorist has contributed to the accident does not relieve the motorist and his no-fault insurer from paying no-fault benefits, but tort actions by the accident victim and in subrogation by the automobile no-fault insurer are permitted against the third-party tortfeasor, as is also true against a third-party tortfeasor under workers' compensation. *Id.* at 372-402.

33. Accident Compensation Act, No. 43, 1 N.Z. Stat. 521 (1972); see Palmer, *Accident Compensation in New Zealand*, 25 AM. J. COMP. L. 1 (1977).

require the government's taxing and redistribution powers. It would substitute government intrusion for private and individual decision-making. It seems, in any event, financially unfeasible. Such a plan of medical no-fault thus seems not within the realm of practicality or desirability.

#### NEEDED REFORMS TO MEDICAL MALPRACTICE LAW

In health care, therefore, the tort system based on fault cannot be abandoned.<sup>34</sup> But the current tort system can still be modified to encourage payment for more patients who suffer from adverse results of treatment, in an amount which fairly reflects their need and which reduces the time and transaction costs of making that payment. Our proposal would strongly encourage—but not require—the payment of compensation to malpractice victims promptly and without litigation; hence the title of this article: "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss." It would use money which now is expended in transaction costs, in fortuitous payment of non-economic damages and in duplicate payment from collateral sources to some plaintiffs, to provide meaningful compensation to more victims, more quickly.<sup>35</sup>

The malpractice system is a matter of state law. At the same time, the federal government has a special role in health care; it assists in the financing of health care for millions of Americans: beneficiaries of Medicare and Medicaid, veterans, armed forces personnel and their families, and its own employees. The federal government annually expends many billions of dollars to provide health care for these people. The current tort system provides an unsatisfactory form of redress for these beneficiaries. At the same time it raises the cost of health care provided to them, and thus the amount the federal government must expend to provide assistance.

Our proposal therefore attempts to balance the states' responsibility for determining the shape of their tort systems with the federal government's need for change. It sets forth what we believe are needed reforms in the medical malpractice system. And it provides that these reforms will apply to care provided to beneficiaries of the federal health programs after January 1, 1987, unless the state in which the beneficiaries reside has enacted its own law like that proposed for the federal beneficiaries but

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34. For the proposition that at least some injuries in the course of medical treatment can be based on no-fault criteria, see O'Connell, *An Alternative to Abandoning Tort Liability: Elective No-Fault Insurance for Many Kinds of Injuries*, 60 MINN. L. REV. 501, 523-28 (1976).

35. For the justification for changing the compensation system to afford lesser payments, consisting of the victim's real economic losses, to more accident victims, compared with present tort payouts of more payment, including coverage for non-economic losses, to fewer victims, see O'Connell, *supra* note 3, at 612-13. For a discussion that damages for pain and suffering violate insurance doctrine, economic theory and administrative efficiency, see O'Connell, *A Proposal to Abolish Defendants' Payment for Pain and Suffering in Return for Payment of Claimants' Attorneys' Fees*, 1981 U. ILL. L. REV. 333-48, 366-68.

applicable to all health care provided in the state. Thus, if the states enact their own reforms for all health care, the federal government will not need to act on its own. But if a state does not do so before January 1, 1987, the federal legislation will take effect and govern medical malpractice occurrences suffered by federal beneficiaries.

The terms of our proposal can be outlined briefly.<sup>36</sup>

The law would encourage hospitals and physicians to compensate the patient for his net economic loss suffered because of adverse results from treatment. This loss would consist mainly of the costs incurred for further medical and hospital care, for rehabilitation and nursing care, for lost wages, for the costs of obtaining a housekeeper, and for adapting the patient's house and car to his incapacitated condition. The law would provide that if a hospital, physician, or other health care provider tenders an offer to pay periodically this amount within the required time, the patient's ability to bring an action in tort would be superseded (with certain exceptions discussed below). In exchange for the agreement to pay for economic loss, the patient would relinquish the ability to sue for non-economic loss. If the physician or hospital did not make an offer within the required time, or if the injured patient believed that one of the exceptions applied and rejected the tender, he could bring a tort action as under present law.

Hospitals and physicians often feel uncomfortable and indeed believe that they are acting contrary to their caring mission when they deny that any harm occurred to a patient, or that they were responsible for it. They are deterred from making the admission by requirements of insurance companies, by fear of adverse publicity, and, most importantly, by fear of the huge judgments that can result under the present system from an admission of culpability. Our proposal would encourage the provider to act consistently with its humanitarian purpose. It would give hospitals and physicians and other health care providers positive incentives to identify and disclose events which could give rise to malpractice actions and to make a prompt offer to pay for losses from those adverse medical results.

The provider would be able to foreclose a tort action only if it made the required offer within 180 days of the patient's discharge from an institution or, if the event did not occur in the course of an admission, within 180 days of the event giving rise to the possible malpractice claim. Under the bill, the provider would not await a claim; it would be required to make the offer within the required time regardless of whether a claim was made. This will provide meaningful incentives for providers to ascertain potentially actionable occurrences and to inform the patient thereof.<sup>37</sup>

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36. The statute is an outgrowth of the ideas expounded in O'Connell, *supra* note 3.

37. The statute could be drafted such that the tender could be triggered primarily by a tort claim rather than by defendant's discovery of the injury. That would be especially

Once a provider has made a commitment to pay the victim's economic loss, it is required within thirty days to make payments for any losses already incurred and to continue to make them as further losses are incurred.

The legislation thus contemplates that payments be made as loss accrues. It provides, however, that, if the parties agree, and a court approves, a lump sum payment may be made to the victim. (The legislation authorizes the court to make provisions to prevent dissipation of the fund.) Any amount which the victim would be entitled to receive from collateral sources would be netted against the amount the provider would be obligated to pay.

The bill also permits the provider and the patient to agree that the provider may discharge its liability by a tender of less than full economic loss. It is unwise, and probably impossible, to prevent people from making their own arrangements. However, to avoid the risk that an unscrupulous provider or its insurance company might take undue advantage of an injured patient any settlement for payment of less than full economic loss (if the economic loss exceeds \$5000) would have to be approved by the court to be effective. If such a lesser settlement were required to be submitted to a court, but was not submitted, the settlement would not be effective, and the patient would have the same rights as any victim of malpractice to whom a tender is not made.

The injured patient is assured by the provider's tender that he will be made financially whole for the injury without having to bring suit and suffer the uncertainty and delay of litigation. In exchange for this certainty, and the inducements to the provider to make the tender, the patient gives up an opportunity to participate in the litigation lottery, which admittedly for some victims results in recovery for non-economic damages.

Under the present system attorneys' fees owed by a prevailing plaintiff are often paid out of the non-economic damages; that extra payment thus funds the payment of contingent fees.<sup>38</sup> Because these elements of damages would be eliminated, the bill provides that, in addition to paying the patient's net economic loss, the tendering provider would pay reasonable expenses, including attorneys' fees, incurred by the victim in obtaining legal advice about the tender and collecting benefits.

The bill provides that either the physician or a hospital or other provider<sup>39</sup> which believes it is at risk of liability for an event may make

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more sensible for a bill allowing tenders to foreclose tort claims by other than health care providers (such as those facing, for example, products liability generally or occupiers' liability for slips and falls, where the injurer is less likely than a health care provider to know of the injury in the absence of a claim). See O'Connell, *supra* note 3, at 601, 615-17, 624-26.

38. O'Connell, *supra* note 35, at 351.

39. The bill includes as providers not only hospitals but also skilled nursing facilities,

the offer to the injured patient. The provider making such a tender may also designate any third person who may be liable as a participant in the tender. The issue of whether or in what amount a third person must contribute to the amount to be tendered would be determined in a separate proceeding.<sup>40</sup> A third person so designated would receive the same protection against tort suits as a tendering provider. Although a third person thus can be forced to participate in the tendering process against his will, he will not, as a practical matter, be disadvantaged by being a participant in a tender: He thereby avoids exposure to liability for non-economic tort damages (including pain and suffering), and can still deny and dispute any liability on his part under the tender.<sup>41</sup> Thus if a hospital makes a tender, it may designate a physician as a co-tenderer. A physician may similarly designate the hospital. Either tenderer may also designate a drug or equipment manufacturer or other person who may be liable. A third party who is a non health care provider may also require the physician or hospital making a tender to include such party within the tender, but the third party may not require a health care provider to make a tender.<sup>42</sup>

When a tender is made and more than one person is designated as a participant in it, the participants may agree upon their relative contribution to the compensation to be paid to the victim. It can be expected that this agreement will be made informally and expeditiously among insurance companies and other organizations which know they will be dealing with each other on an on-going basis, and, consequently, that they will make common-sense settlements. If they fail to do so, however, this question will be submitted to arbitration to be decided on the basis of relative fault among the participants in the tender.<sup>43</sup>

In this way, the victim is protected from evasive finger-pointing among the various parties who may be liable, and by the same token, cannot play one off against the other. The patient receives compensation. The participants are obligated to pay that compensation, and their insurers determine their respective shares of it.

The bill would not permit the provider to preclude a tort action in

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home health agencies, rural health clinics, comprehensive outpatient rehabilitation facilities, and hospice programs.

Note the bill does not change current practices as to whether an insurer must obtain approval from the insured health care provider of the former's decisions relating to settlement.

40. See *infra* note 43 and accompanying text.

41. *Id.*

42. The bill permits only a provider to make the tender, although third parties could participate in any tender made. These third persons are not, in most instances, in direct contact with the patient as are the hospital and the physician, and the patient looks to the hospital and the physician to provide the care. The decision whether to make a tender is most appropriately left to them.

43. At common law, any defendant could implead any third person in a tort action; thus, involving such third person in the tender can be viewed as a form of impleading.



two categories: where a wrongful death action could be brought and where the provider's malpractice was intentional.<sup>44</sup> If the victim elected to rely on the exception for intentional malpractice, he would notify the hospital or physician making a tender that he was rejecting that tender. Thus the patient could not receive payment for economic loss and then sue in tort, alleging that the exception applied.

It may be necessary to add a third exception, but we have not done so in the bill because of concern that such an exception would be expanded to provide too broad a loophole for arguably sympathetic cases. The issue is how to treat injuries which are grievous but which result in little or no economic loss. Is the injured patient fairly compensated in such a case by payment of economic loss? Should the patient have the option to resort to conventional tort actions? Can a standard be imposed that would give courts discretion to permit conventional tort actions in some cases, without creating a loophole for too many cases?

If society believes foreclosure of tort actions is unconscionable where the victim would receive a small recovery for a severe injury, it might be possible to include a provision that permits a judge to allow the foreclosure of a tort action to be overridden in exceptional circumstances. Such a standard might be found in the doctrine of current tort law relating to proof of fraud of settlements voluntarily made. The standard could be that when a court, as a matter of law, would have found the payment of compensation benefits plus amounts payable by collateral sources, if it had been a voluntary settlement, so inadequate as to allow the settlement to be set aside,<sup>45</sup> the court should not permit foreclosure of the tort action by virtue of a tender.

Rarely are victims of misfortune, whether injury, crime, unemploy-

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44. The definition of *intentional* is as follows:

A person intentionally causes or attempts to cause a personal injury when the person acts or fails to act for the purpose of causing injury or with knowledge that injury is substantially certain to follow; but a person does not intentionally cause or attempt to cause injury merely because the individual's act or failure to act is intentional or is done with the individual's realization only that it creates a grave risk of causing injury without the purpose of causing injury or if the act or omission is for the purpose of averting bodily harm to the individual or another person.

For the necessity of thus rigidly defining intentional conduct as opposed to including gross negligence, see J. O'Connell, *Ending Insult to Injury: No-Fault Insurance for Products and Services* 154-55 (1975); W. Prosser, *Handbook of the Law of Torts* § 34, at 186-87 (4th ed. 1971).

• 45.

Although mere inadequacy of consideration is not sufficient of itself to set aside a release [at common law], it is a factor to be considered along with other evidence to determine the existence of fraud; however, if the consideration is so grossly and palpably inadequate as to shock one's moral sense, it alone is sufficient to bring the question of fraud to the jury.

3B *Personal Injury: Actions, Defenses, Damages* § 4.01[1][a] at Dis—147-48 (L. Frumer

ment, underemployment, *etc.*, guaranteed prompt payment of all—or even the great bulk—of their pecuniary losses. The program we propose will provide more compensation for pecuniary loss, more promptly paid, and for more victims of medical malpractice with far fewer transaction costs than the present system. The theory behind the legislation, then, is that society should determine that prompt payment to a victim of all his pecuniary loss is a fair disposition of medical malpractice cases, given all the expense, delay, and uncertainty in establishing liability. In this connection, even for the white collar worker who suffers an amputation, an injury which may result in little or no economic loss to him, the guarantee of all losses, including rehabilitation, plus psychiatric and other counseling, would seem to provide fair compensation.

Since the bill permits the tortfeasor to foreclose actions for non-economic damages, there is a danger of adverse selection. The concern is that providers will make tenders only in those cases in which their conduct has been most faulty and in which it is most likely that a tort action would result in a large judgment, and conversely, that they will not make a tender in the marginal cases in which they do not perceive a substantial risk of liability. But the premise of the proposal is that society is better off if even the clearly faulty (but not intentional) tortfeasor is not required to pay a large judgment for non-economic damages after lengthy and expensive litigation, so that victims may be provided fair compensation for economic loss quickly and without expensive and bitter litigation.

Even when liability is doubtful, the health care provider will have an incentive to tender the patient's net economic loss whenever the provider's litigation costs will exceed the patient's net economic loss. The large litigation expenses common in malpractice cases<sup>46</sup> will thereby encourage the health care provider to pay patients' net economic losses rather than defense lawyers—arguably a much more socially beneficial use of precious insurance dollars.

The provider also may well be likely to settle for the injured patient's net economic loss when it faces possible liability for large amounts in excess of economic loss, whether in the form of an award for pain and suffering or in the form of punitive damages.<sup>47</sup> The proposed system provides a safety valve. The defendants cannot require such a settlement (1) if the provider has intentionally inflicted injury, or (2) the injury results in death. As to all other cases, both large and small, it makes sense for society to encourage elimination of expensive legal disputes. Especially is this so in that payment for pain and suffering is expensive to determine<sup>48</sup>

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ed. 1980). For alternate but similar—if less restrictive—tests, see O'Connell, *supra* note 3, at 601-02.

46. O'Connell, *supra* note 3, at 590-91.

47. As to the latter, see *supra* note 2.

48. *Id.* at 491-92.

and counter-productive compared to using insurance dollars to pay for dollars lost.<sup>49</sup>

The health care provider will also have an incentive to settle for the patient's net economic loss regardless of the provider's doubtful liability whenever the injured patient's collateral sources cover most of his special damages. This too makes economic sense given the waste of either double payment to the patient or of subrogation to a liability claim by a loss insurer.<sup>50</sup> Rather than promote such waste, it is far better to permit the health care provider, in effect, to use the amount of an injured patient's collateral sources, either alone or in combination with amounts otherwise spent on counsel fees and pain and suffering, to pay for a patient's otherwise unreimbursed losses, thus allowing the parties—and society—to be rid of the claim with such payment of the patient's essential losses.<sup>51</sup>

#### WHY REQUIRE SETTLEMENT?

Nothing prevents the hospital or the physician under present law from settling a claim with a patient. Our proposal would give the provider the option of requiring the patient to forego the tort action in exchange for a promise to pay his net economic losses. The provider thus would have the ability to impose a settlement. Is that result fair and proper? We believe that it is, because it would encourage more settlements for more victims than is possible under the current system. The deficiencies of the present

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49. See authorities cited *supra* note 35.

50. O'Connell, *supra* note 3, at 593.

51. In view, however, of the risk of adverse selection by the health care provider, another provision might be added to advantage the victim of an adverse medical result who has not been tendered his net economic loss and yet does not wish to undergo the delay of tort litigation; thus, when the 180 day period within which a tender must be paid has expired, and thereafter a patient makes a malpractice claim, the health care provider will be obligated to offer the patient the option, in addition to a regular malpractice claim, of arbitrating within 90 days of the claim claimant's right, based on proof of the health care provider's negligence, to receive the benefits due under a tender, namely, net economic loss, payable periodically, plus reasonable counsel fees if the claim is successful. (Note payment of counsel fees by the health care provider, in addition to net economic loss, is required to reimburse the victim's economic loss, assuming no payment for pain and suffering. See *supra* note 38 and accompanying text.) Thus, the patient not tendered net economic loss who would prefer a quick, less formal adjudication of his allegation of malpractice, payable only for net economic loss, will be entitled to that option, as opposed to a more formal malpractice claim for common law damages. Because the failure of the health care provider to tender will signal the difficulty of proof of malpractice, and because, as with a normal tort claim, claimant's counsel will be paid only if he wins, frivolous claims for net economic loss will be discouraged. (Note also that a health care provider not making a tender should not be required to notify the patient to that effect. Such notification would entail an overly broad, cumbersome, bureaucratic burden under which a health care provider would be required to notify almost every patient of the lack of tender; rather, when no tender is made, the burden should be on the patient to claim a compensable injury.)

system are both the cause and effect of the present insufficient number of settlements.

Defendants rarely make early offers as generous as that which would be required by the proposal. They and their insurance company are locked in the adversarial mode. Time is on the defendant's side, since it has the use of any money it may ultimately have to pay. And the more needy the plaintiff, the stronger the defendant's position and its incentive not to make a settlement offer; the defendant knows it can outlast the claimant who most needs a settlement. Defendants may also fear that making such an offer will just encourage the claimant to believe that he can recover even more if he perseveres through litigation. For this latter reason defendants often fail to settle promptly for the claimant's net economic loss, even when it might be thought advantageous for them to do so.<sup>52</sup>

And when they do make a settlement offer, claimants or their lawyers frequently reject it because they see it as a sign, as defendants fear they will, that the case is worth much more.<sup>53</sup> So the lottery aspects of the present system and the possibility of a very large recovery spur the plaintiff on. Nor, as just suggested, should the role of the plaintiffs' attorneys be underestimated. Because they often are interested in the "big hit," they have an incentive to take the case to trial, risking the chance of recovering nothing for the opportunity to strike it rich. They typically have a number of contingent fee clients and thus are able to spread the risk of recovering nothing over all of them. The plaintiff, on the other hand, does not have this "portfolio diversification," and his ability to recover is wrapped up in only one case—his own.<sup>54</sup>

Our proposal is designed to increase greatly the number of cases that are settled along the terms outlined, by providing incentives to providers to make more generous and early settlement offers in a larger number of cases in exchange for protection against paying damages for non-economic loss.

#### EFFECT OF DETERRENCE

The proposal will be criticized on the ground that it removes the deterrent effect of damages for pain and suffering and of punitive damages. Under this theory a potential tortfeasor is deterred from negligent behavior by the possibility that he will be required to pay these extra, non-economic damages.

We do not believe our proposed modifications to the tort system would result in any undesirable changes in provider behavior. In the first place,

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52. *Id.* at 604.

53. *Id.*

54. *Id.* at 604-05.

the *possibility* of being liable in tort is still present. It is only by tendering an injured patient's net economic loss—a not insufficient commitment of itself—that a tort claim is foreclosed (and not in every case).<sup>55</sup> Secondly, the extent to which people avoid negligence because of the possibility of tort damages is speculative at best.<sup>56</sup> In addition, this criticism erroneously assumes that it is the defendant who pays the damages; in fact, of course, it is insurance companies and ultimately other patients of all hospitals or physicians who pay, in the form of increased fees to offset increased premiums.

Professional pride, the opinion and review of one's peers, and the fear of adverse publicity are all effective deterrents. None of those would be eliminated by the proposal. With workers' compensation and automobile no-fault laws, society abandoned substantial blocks of tort liability without any apparent adverse effects on deterrence of negligent conduct.<sup>57</sup> And we do not propose for medical malpractice the elimination of tort, but only the restriction of payment for non-economic damages. Indeed, we recommend the expansion of the instances in which compensation for economic loss would be paid, providing ample new incentives for providers not to be negligent. We believe, therefore, that the proposal will not have any adverse effect on a provider's desire to provide quality care.

We also believe the proposal will reduce the extent to which defen-

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55. *Id.* at 619.

56. *Id.* at 618.

Compensation law . . . seeks to achieve other meaningful objectives that are not as elusive as deterrence. Among these objectives are administrative efficiency and loss distribution. The proposed statutory scheme achieves administrative efficiency because it reduces payments to lawyers, [insurance] adjusters, and other third parties in the system; and it achieves loss distribution because it leaves fewer accident victims and their families without resources. Compared to the goal of deterrence, these two objectives are more readily attainable. It makes sense to risk a remotely possible loss of deterrence to achieve the proposal's improvements in loss distribution and administrative efficiency.

*Id.* at 620 (footnotes omitted). For a very searching indictment of the cumbersome tort system, see Tullock, *Welfare and Law*, 2 INT'L REV. LAW & ECON. 151 (1982); Tullock, *Negligence Again*, 1 INT'L REV. LAW & ECON. 51 (1981). Tullock bases his indictment on (1) the tort system's very costly and often wasteful and manipulative adversary efforts at proving or disproving fault, (2) its likely errors in determining same, and (3) its failure to distribute losses. Tullock correspondingly emphasizes how much legal-economic analysis fails to consider the beneficial—and even economically efficient—effects of no-fault or similar payment schemes.

For further scholarly skepticism about the beneficial deterrent effects of tort rules, see Epstein, *The Social Consequences of Common Law Rules*, 95 HARV. L. REV. 1717 (1982); Pierce, *Encouraging Safety: The Limits of Tort Law and Government Regulation*, 33 VAND. L. REV. 1281 (1980).

57. U.S. Dep't of Transp., *State No-Fault Automobile Insurance Experience* 60 (1977). But see Landes, *Insurance, Liability, and Accidents: A Theoretical and Empirical Investigation of the Effect of No-Fault Accidents*, 25 J. L. & ECON. 49 (1982). For a reply to Landes, see O'Connell & Levmore, *A Reply to Landes: A Faulty Study of No-Fault's Effect on*

sive medicine is practiced and thus improve the quality of care and reduce the costs of health care. As we have seen, physicians say that, because of the increase in malpractice awards, they order more tests and provide more treatment procedures than they otherwise would.<sup>58</sup> To the extent that the proposal would avoid fault-finding (as well as some of the extremely large verdicts—which are the ones which make the headlines in the local community and to which the physicians naturally react), we believe it would reduce the pressure on physicians to order tests and treatment procedures for legal protection purposes only. By doing so it will save patients money and the inconvenience and risk of unnecessary tests (as well as the cost of same).

#### CONCLUSION

The fault-based tort system is not meeting societal goals as it is applied to medical malpractice claims. Only a small proportion of the victims of malpractice are recovering fair compensation for their losses, while unusually large recoveries are conferred on a few others. Providers of health care are faced with ever-increasing premiums for malpractice insurance and are forced to engage in defensive medicine. Vast amounts of time and money are expended in litigation to reach these unsatisfactory results. We propose reforms, not to eliminate the fault-based system, but to facilitate fair settlements for more people, more quickly reached, and more promptly paid. The fault-based system would remain. No provider would be required to make a settlement where it believed it was not at fault; it could still defend against liability in court. But providers would be encouraged to make prompt settlements to avoid the lengthy litigation process and to pay more victims fairly with the money that now is being spent on, among other things, transaction costs.

We have embodied our proposal in “model” legislation for consideration by the states, which are responsible for the operation of the medical malpractice system. To ensure that at least the beneficiaries of federal assistance receive the benefits of the reform we suggest, it will be applicable to health care obtained by patients with federal assistance after January 1, 1987, in any state which has not prior to that date reformed its medical practice system across the board in line with the bill.<sup>59</sup>

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*Fault?*, 48 Mo. L. Rev. 649 (1983). Cf. 2 F. HARPER & F. JAMES, THE LAW OF TORTS § 13.5 at 775-76 (1956).

58. Report, *supra* note 5, at 14; J. O'Connell, *supra* note 44, at 48-50.

59. We do not have much doubt that this proposal will pass constitutional muster. No-fault automobile laws have generally done so, *see, e.g.*, *Pinnick v. Cleary*, 360 Mass. 1, 271 N.E.2d 592 (1971), as did eventually their workers' compensation forerunners, *see, e.g.*, *New York Cent. R.R. v. White*, 243 U.S. 188 (1917). For an extensive discussion of the constitutionality of a proposal analogous to the one under discussion, including the issue of federal supersession of state law, *see* O'Connell & Souk, *Is It Constitutional?*, in J. O'Connell, *supra* note 44, at 204-45.

